D Appendix D: Forms

Forms to Copy

The following forms can be copied and used by providers as needed:

- Accommodation and Room Rates Schedule
- Adjustment/Void Request Form (with instructions)
- Administratively Necessary Day (AND) Intake Form
- Affiliation Roster (Group)
- Affiliation Roster (Individual)
- Authorization for Electronic Funds Transfer
- Certificate of Medical Necessity (CMS-484, with instructions)
- Change of Provider Information Authorization Form
- Disclosure of Ownership and Control Interest Statement
- Electronic Claims Submission Certification and Authorization
- Hospice Intake Form
- Idaho Department of Health and Welfare: Qualified Providers—Presumptive Eligibility (PEDS)
- Idaho Medicaid Contact Lens Prior Authorization Request
- Idaho Medicaid Dental Medical Necessity Review Form
- Idaho Medicaid Dental Program: Dental Prior Authorization Form (General)
- Idaho Medicaid Dental Program: Dental Prior Authorization Form (Orthodontics)
- Idaho Medicaid Dental Program: EPSDT Request Form (Interceptive Orthodontics)
- Idaho Medicaid Durable Medical Equipment (DME)/Supplies Request Form
- Idaho Medicaid Electronic PA Request Attachment Cover Sheet
- Idaho Medicaid Healing Arts Therapy Prior Authorization (PA) Request
- Idaho Medicaid Surgery and Medical Treatment Prior Authorization Request
- Idaho Psychosocial Rehabilitation Services Service Plan Authorization
- Medicaid Non-Emergent Transportation Request (with instructions)
- Medical Necessity Form (pregnancy related)
- NDC Detail Attachment
- NDC Attachment (Compound Detail)
- Notification of Birth Form: Anticipated Stays Greater Than 72 Hours
- Order Form Instructions
- Personal Care Services Progress Notes (with instructions)
- Request for Additional Crisis Service Coordination Hours
- Request for Taxpayer Identification Number and Certification (W-9)
- Signature-on-File Form
- Vision Prior Authorization Request

Note: To print a form, select Print from the Acrobat Reader tool bar and select Current Page or enter the page number.

Forms to Order from EDS

• Drug Claim Form	352-023
• Notice of Admit or Discharge: NF or ICF/MR	HW0458
• PASARR Screen Form	HW0087
• PCS Assessment and Care Plan	RMU 14.01
• PDN Flow Chart	HW0622
• PDN Addendum	HW0622A
• Physicians Medical Care Evaluation for PCS	HW0603 3/98
• QMRP Assessment	HW0615
• QMRP Visit	HW0621
• Sterilization Consent Form	HW0034
• Sterilization Consent Form (Spanish version)	HW0034—Spanish
• Visit Notes for Supervising Nurses	HW062

Accommodation and Room Rates Schedule

Name of Institution:_____

Idaho Medicaid Provider Number:_____

Total Number of Licensed Hospital Beds:_____

Enter the usual and customary rate and the effective date for each applicable accommodation revenue code. Only the codes listed may be updated. This schedule is not required for Dialysis Units.

Authorized Signature:_____ Date:_____

Name Printed or Typed:_____

Return to: EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

Fax: (208) 395-2198

Revenue Code	Accommodations	Rate	Effective Date
101	All Inclusive Room/Board		
111	Medical/Surgical/GYN		
112	Obstetric		
113	Pediatric		
114	Psychiatric		
116	Detoxification		
117	Oncology		
118	Rehabilitation		
120	Semi-Private		
121	Medical/Surgical/GYN		
122	Obstetric		
123	Pediatric		
124	Psychiatric		
126	Detoxification		
127	Oncology		
128	Rehabilitation		
130	Semi-Private		
131	Medical/Surgical/GYN		
132	Obstetric		
133	Pediatric		
134	Psychiatric		
136	Detoxification		
137	Oncology		
138	Rehabilitation		
140	Private		

Revenue Code	Accommodations	Rate	Effective Date
141	Medical/Surgical/GYN		
142	Obstetric		
143	Pediatric		
144	Psychiatric		
146	Detoxification		
147	Oncology		
148	Rehabilitation		
150	Room and Board - Ward		
151	Medical/Surgical/GYN		
152	Obstetric		
153	Pediatric		
154	Psychiatric		
156	Detoxification		
157	Oncology		
158	Rehabilitation		
164	Sterile Environment		
170	Nursery		
171	Newborn		
172	Premature		
173	Neo-Natal Intensive Care Level III		
174	Neo-Natal Intensive Care Level IV		
200	Intensive Care Unit		
201	Surgical		
202	Medical		
203	Pediatrics		
204	Psychiatric		
207	Burn Care		
208	Trauma		
210	Coronary Care Unit		
211	Myocardial Infarction		
212	Pulmonary Care		
213	Heart Transplant		

Adjustment/Void Request Form

1. Provider Medicaid Number (required): _____
2. Provider Name: _____
3. Provider Address: _____

   _____ Zip: _____
4. Claim ICN: _____
5. National Provider Identifier (NPI): _____
6. Participant Medicaid Number: _____
7. Participant Name: _____
8. RA Number: _____
9. RA Date: _____

10. Correct Billing Information:

Claim Line (pptional)	Incorrect Information on Claim	Correct Information for Adjustment

11. Requested Action:

- ☐ I am refunding the overpayment for the following reason: (Attach check made out to: **State of Idaho**)
  - ☐ Billed In Error ☐ Medicare Primary ☐ Wrong Patient Liability ☐ Duplicate Payment
  - ☐ Other Insurance Primary ☐ Wrong Procedure ☐ Items Returned ☐ Services Not Rendered
  - ☐ Wrong Units Other: _____
- ☐ Please withhold overpayment in a future Medicaid warrant with an adjustment.
- ☐ Please pay me more in a future warrant due to an underpayment by Medicaid.

12. Signature: _____
13. Date: _____

EDS Use Only

Related History ICN: _____

Action: _____

_____

Mail to: EDS
PO Box 23
Boise, ID 83703

Information: (800) 685-3757

DO NOT FAX THIS FORM

Adjustment Request Form Instructions

This Adjustment Request Form can be duplicated for use as needed. When making copies, it is not necessary to copy these instructions also. Adjustment requests must be mailed. Please do **not** fax this form.

1. Provider Medicaid Number: enter your 9-digit Medicaid provider identification number. Do **not** use a Social Security or FEIN number. This number is in the upper left-hand corner of the first page of your remittance advice (RA).

2. National Provider Identifier (NPI) Number: (If you are required to have an NPI) Enter your 10-digit NPI number.

3. Provider Name: Enter your provider name. This is in the lower right-hand corner of the first page of your RA.

4. Provider Address: Enter your mailing address. This is in the lower right-hand corner of the first page of your RA.

5. Claim ICN: This is the unique 15-digit claim identification number. It is found on the Paid Claim page of your RA following the participant's MID.

6. Participant Medicaid Number (MID): enter the 7-digit participant Medicaid Identification Number. It is found on the Paid Claim page of your RA following the participant's name. Do not use a Social Security number.

7. Participant Name: Enter the participant's name as it is on the RA. It is found on the Paid Claim page of your RA.

8. RA Number: This is in the upper right-hand corner of the first page of your RA.

9. RA Date: Enter the date from the RA. This is at the top of the first page of your RA.

10. Correct Billing Information: simply and clearly state what the correct billing information should have been on the claim. If a line of a claim needs to be corrected, enter the line number from the claim form. Enter what was wrong on the line and the correct information to replace it.

    Example: A claim is incorrectly billed with one hundred (100) units on line four (4) and, after the claim is submitted, the provider receives a check from other insurance. The correct number of units is ten (10) and the insurance amount is $1124.47. Complete the form as shown:

Claim Line (Optional)	Incorrect Information on Claim	Correct Information for Adjustment
4	100 Units Billed	Correct Number of Units is 10
		Other Insurance Paid $1124.47

11. Requested Action: Select the appropriate box. If you owe a refund to Medicaid because of an overpayment, you can send a check for the amount or request that the overpayment be deducted from future warrants. Make checks payable to: **State of Idaho**.

12. Signature: The person who completes this form must sign and date it.

Adjustments may be initiated by:

- Providers
- EDS to recoup incorrect payments
- DHW for recoupments of retroactive rate adjustments

Adjusted claims are grouped together in the RA by provider service location. Each service location has a separate section. Within provider service location, the adjusted claims are sorted by participant last name. Grand totals are calculated to reflect the net effect of all adjustments.

Administratively Necessary Day (AND) Intake Form

Fax to: Idaho Medicaid, Medical Care Management
(208) 332-7280

Date	
Requesting Agency Name	
Contact Person	
Phone Number	
Fax Number	
Address	
Hospital Medicaid Provider Number	
Attending Physician	
Hospital Admission Date	
Patient Name	
Medicaid Number	
Diagnosis	
ICD-9 Codes	
Reason for AND Request	
AND Dates Requested	
Supporting Documents Required (Please Attach the Following)	• Summary of Patient's Medical Condition • Current History and Physical • Physician Progress Notes • Statement as to why Patient can not receive necessary medical services in a non-hospital setting • Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services
MEDICAID USE ONLY	
Number of AND Approved	
Dates Approved	
Authorization Number	
Request Denied	
Reason Denied	
Log Completed By (Staff Signature)	

Group Affiliation Roster

This page is used by groups to affiliate individual Medicaid providers with the group. Providers must be enrolled as individuals before **they can be affiliated with a group. If more space is needed, copy this page and complete the listing. Listing a provider on this roster does not** enroll the individual in the Idaho Medicaid program. Do **not** list individuals who will not be furnishing Medicaid services or who are not enrolled as Medicaid providers.

Note: Each provider listed on this roster must sign and date this sheet. No other person can be authorized to sign for an individual provider.

Group Name: _____ **Group Number:** _____

Individual Provider Name (Print Name)	Idaho Medicaid Individual Provider Number	Individual Provider Signature	Date Signed	Date Effective

Mail to: EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

Fax to: EDS
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

Individual Affiliation Roster

This roster is used by individual providers who wish to affiliate with a group (or groups) already enrolled in the Idaho Medicaid program. Providers must be enrolled as individuals **before** they can be affiliated with a group. Being included in a group enrollment **does not** enroll the individual with Medicaid.

Do **not** complete this page if you are an individual provider not affiliated with a group practice.

Note: Listing a group on this form does **not** enroll the group in the Idaho Medicaid Program.

Note: The individual provider must sign and date this sheet. No other person can be authorized to sign for an individual provider.

Group Name (Print Name)	Idaho Medicaid Group Provider Number	Date Signed	Date Effective

I wish to be affiliated with the above listed group(s) in the Idaho Medicaid Program.

Signature: _____

Name (Typed or Printed): _____

Provider Medicaid Identification Number: _____

Date: _____

Mail to: EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

Fax to: EDS
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

Authorization for Electronic Funds Transfer

Complete all the sections below **if** you wish to have your payments automatically deposited to your bank. The transaction routing number can be obtained from your bank.

Important: You must include a letter from your bank verifying your transaction routing number and account number. For deposits to a checking account, you may instead include an original voided check or copy of a voided check. If you include a voided check, tape it in the space provided below. (Please do **not** staple the check).

Provider Name: _____

Bank Name: _____ **Bank Phone Number:** _____

Bank Address:

_____

_____

Account Number: _____

Transaction Routing Number (Nine Digits): _____

Type of Account (Circle Only One): **Checking** **Savings**

I authorize the electronic transfer of Idaho Medicaid payments made to the above provider. I understand that I am responsible for the validity of the above information.

Authorized Signature: _____

Name Typed or Printed: _____

Idaho Medicaid Provider Number: _____

Date: _____

Mail to: EDS
Attn: Provider Enrollment
PO Box 23
Boise, ID 83707

Fax to: EDS
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

For Checking Account Deposit Only
(Tape Voided Check Here)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB NO. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY
CMS-484—OXYGEN

DME 484.03

SECTION A CERTIFICATION TYPE/DATE: INITIAL __/__/__ REVISED __/__/__ RECERTIFICATION __/__/__

PATIENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE AND NSC OR APPLICABLE NPI NUMBER/LEGACY NUMBER
(__ __ __) __ __ __-__ __ __ __ HICN _____	(__ __ __) __ __ __-__ __ __ __ NSC OR NPI #_____

PLACE OF SERVICE _____	HCPCS CODE	PT DOB __/__/__ SEX M/F
NAME AND ADDRESS OF FACILITY (IF APPLICABLE – SEE REVERSE)	_____ _____ _____ _____	PHYSICIAN NAME, ADDRESS, TELEPHONE AND APPLICABLE NPI NUMBER OR UPIN (__ __ __) __ __ __-__ __ __ __ UPIN OR NPI #_____

SECTION B INFORMATION IN THIS SECTION MAY NOT BE COMPLETED BY THE SUPPLIER OF THE ITEMS/SUPPLIES

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99 = LIFETIME) | DIAGNOSIS CODES (ICD-9) ___ ___ ___ ___

ANSWERS	ANWSER QUESTIONS 1-9. (CIRCLE Y FOR YES, N FOR NO, OR D FOR DOES NOT APPLY, UNLESS OTHERWISE NOTED)
a) _____ mm Hg b) _____ % c) __/__/__	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) for arterial blood gas PO2 and/or (b) for oxygen saturation test, or (c) for date of test.
1 2 3	2. Was the test in Question 1 performed (1) With the patient in a chronic stable state as an outpatient, (2) Within two days prior to discharge from an inpatient facility to home, (3) Under other circumstances?
1 2 3	3. Circle the one number for the condition of the test in Question 1. (1) At rest, (2) During exercise, (3) During sleep.
Y N D	4. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, Circle D.
_____ LPM	5. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter an "X".
a) _____ mm Hg b) _____ % c) __/__/__	6. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) Arterial blood gas PO2 and/or (b) Oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
	ANSWER QUESTIONS 7-9 ONLY IF PO2 = 56-59 OR OXYGEN SATURATION = 89 IN QUESTION 1
Y N	7. Does the patient have dependent edema due to congestive heart failure?
Y N	8. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on and EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N	9. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (PLEASE PRINT)

NAME:_____ TITLE:_____ EMPLOYER:_____

SECTION C NARRATIVE DESCRIPTION OF EQUIPMENT AND COST

Narrative description of all items, accessories and options ordered; (2) Supplier's charge and (3) Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions.)

SECTION D PHYSICIAN ATTESTATION AND SIGNATURE AND DATE

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certification of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE:_____ DATE:_____

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN (CMS-484)

Section A: **(May be completed by the supplier)**

Certification Type/Date: If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL". If this is a revised certification (to be completed when the physician changes the order, based on the patient's change in clinical needs), indicate the initial date needed in the space marked "INITIAL", and indicate the recertification date in the space marked "REVISED". If this is a recertification, indicate in initial date needed in the space marked "INITIAL", and indicate the recertification date in the space marked "RECERTIFICATION". Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.

Patient Information: Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.

Supplier Information: Indicated the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC) or applicable National Provider Identifier (NPI). If using the NPI number, indicate this by using the qualifier XX followed by the 10-digit number. If using a legacy number, e.g. NSC number, use the qualifier 1c followed by the 10-digit number. (For example: 1cxxxxxxxxxx).

Place of Service: Indicated the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, end stage renal disease (ESRD) facility is 65, etc. refer to the DMERC supplier manual for a complete list.

Facility Name: If the place of service is a facility, indicate the name and complete address of the facility.

HCPCS Codes: List all HCPCS procedure codes for items ordered. procedure codes that do not require certification should not be listed on the CMN.

Patient DOB, Height, Weight and Sex: Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.

Physician Name, Address: Indicate the PHYSICIAN'S name and complete mailing address.

Physician Information: Accurately indicated the treating physician's Unique Physician Identification Number (UPIN) or applicable National Provider Identifier (NPI). If using the NPI Number, indicated this by using the qualifier XX followed by the 10-digit number. If using the UPIN number, use the qualifier 1g followed by the 6-digit number. (For example: 1gxxxxxx).

Physician's Telephone Number: Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.

Section B: **(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a Physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating practitioner.)**

Estimated Length of Need: Indicated the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the patient will require the item for the duration of his/her life, then enter "99".

INSTRUCTIONS FOR COMPLETING THE CERTIFICATE OF MEDICAL NECESSITY FOR OXYGEN (CMS-484)

Section B (continued):

Diagnosis Codes:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to four codes).
Question Section:	This section is used to gather clinical information to help Medicare determine the medical necessity for the item(s) being ordered. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no or "D" for does not apply.
Name of Person Answering Section B Questions:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician) or a physician employee answers the questions of Section B, he/she must print his/her name, five his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.

Section C: (To be completed by the supplier)

Narrative Description of Equipment & Cost:	Supplier gives (1) a narrative description of the item(s) ordered, ass well as all options, accessories, supplies and drugs; (2) the supplier's charge for each item(s), options, accessories, supplies and drugs; and (3) the Medicare fee schedule allowance for each item(s), options, accessories, supplies and drugs, if applicable.

Section D: (To be completed by the physician)

Physician Attestation:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.

DO NOT SUBMIT CLAIMS TO THIS ADDRESS. Please see *http://www.medicare.gov/*for information on claim filing.

Change of Provider Information Authorization Form

Provider Number: _____

Effective Date of New Information: _____

Old *Pay-To* Name, Address, Phone Number:

Name: _____

Address: _____

_____

_____

Phone: _____

New *Pay-To* Name, Address, Phone Number:

Name: _____

Address: _____

_____

_____

Phone: _____

(Attach a signed W-9 with effective date if Pay-To name is changing. A change of ownership requires submission of a new application.)

If Mail-To information is not the same as Pay-To information:

Old *Mail-To* Name, Address, Phone Number:

Name: _____

Address: _____

_____

_____

Phone: _____

New *Mail-To* Name, Address, Phone Number:

Name: _____

Address: _____

_____

_____

Phone: _____

Old Tax ID Number:_____

(Attach a signed W-9 with effective date.)

New Tax ID Number:_____

Physical Address Information *(required)*

Service Location (SL) ___

(Last 2 digits of 9-digit provider number)

Old Name, Address, Phone Number:

Name: _____

Address: _____

_____

_____

Phone: _____

New Name, Address, Phone Number:

Name: _____

Address: _____

_____

_____

Phone: _____

Mailing Address Information for this Service Location

Service Location (SL) ___

(Last 2 digits of 9-digit provider number)

Old Name, Address, Phone Number:

Name: _____

Address: _____

_____

_____

Phone: _____

New Name, Address, Phone Number:

Name: _____

Address: _____

_____

_____

Phone: _____

Comments: _____

Provider Signature: _____

Date Signed: _____

Mail to: EDS Provider Enrollment P.O. Box 23 Boise, ID 83707

Fax to: EDS Provider Enrollment (208) 395-2198 **Phone:** (800) 685-3757 - Option *Provider Enrollment*

Disclosure of Ownership and Control Interest Statement

Providers must disclose to the State Medicaid Agency the following information:

1. Enter the legal name of your business: _____

2. Check (√) the applicable Business Category:

   ○Sole Proprietor ○Corporation ○Partnership ○Limited Liability Corporation ○Government

3. **A)** List the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing enitity has direct or indirect ownership of 5% or more (42 CFR §§ 455.104).

   B) List any board members not already listed.

   C) Indicated with a check (√) in the applicable column if the person listed has ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any Federal agency (42 CFR §§ 455.106).

A & B	C		
Name and Address	Sanctioned	Excluded	Convicted

4. Are any of the persons named above related as spouse, parent, child or sibling to any of the other persons named?
   ○Yes ○No If Yes, provider name(s) of person(s) and relationship(s).

   _____

5. Do any of the persons listed in #3 have ownership or control interest of 5% or more in other organizations that bill Medicaid for services? ○Yes ○No If Yes, provider the following for each organization.

Organization Legal Business Name	FEIN	Medicaid Provider Number

_____ _____

Provider Signature Date

Electronic Claims Submission Certification and Authorization

_____, hereinafter referred to as 'Provider', hereby certifies as follows:
(Provider name)

The provider certifies that all services and items for which reimbursement will be claimed shall be furnished by, or under the supervision of, the Provider.

The Provider understands that the use of electronic claims submission does in no way relieve the Provider of responsibilities for (a) maintaining such medical and fiscal records as are necessary to disclose fully the nature and extent of services or items provided by the Provider to Medicaid recipients, and making such records available upon request to the Department of Health and Welfare (DHW) and the United States Department of Health and Human Services; and (b) promptly returning to the Department of Health and Welfare, or its fiscal agent, the amount of any erroneous or excess payments received for services or items provided to any Medicaid recipients.

The Provider certifies that the claim is due; that the Provider is authorized to sign for the payee; that complete records of these services are being kept in hardcopy form for five (5) years and will be provided upon request. The Provider accepts payment in full for the claims submitted subject to adjustment as authorized by Department regulations and certifies that these services have been rendered without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. The Provider certifies that if prescription services are provided, a legal prescription is on file for each medication issued.

The Provider certifies that all services and items from which reimbursement will be claimed shall be provided in accordance with all Federal and State laws pertaining to the Idaho Medicaid Program, and that all charges submitted for services and items provided shall not exceed Provider's usual and customary charges for the same services and items when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

The Provider understands that any payments made in satisfaction of claims submitted will be derived from Federal and State funds and that any false claims, statements, or documents, or concealment of material fact may be subject to prosecution under applicable Federal and State law.

If the Provider uses a billing service, the provider agrees to report completely and accurately to the billing service all information necessary to ensure compliance with Federal and State laws pertaining to the Idaho Medicaid Program, as amended.

The Provider understands that the Department reserves the right to revoke its approval for electronic claims submission, at any time, for failure on the part of the Provider or billing service to comply fully with any or all guidelines governing the submission of electronic claims.

The Provider holds EDS harmless and indemnifies EDS against any liability to the Provider, the State of Idaho, or to any Medicaid Provider arising out of the entering into this agreement or subsequent receiving and processing of Medicaid claims by tape or other electronic media.

SECTION I

DHW shall allow Providers to enter Medicaid claims through the claims entry system developed by the Department's fiscal agent and designated Electronic Claims Submission (ECS), or through the use of entry screens developed by authorized computer vendors, or by magnetic tape or cartridge.

Both EDS and the State of Idaho must approve of any provider **prior** to the submission of electronic claims.

The Provider shall allow the Department access to claims data and assure that submission of claims data is restricted to authorized personnel so as to preclude erroneous payments resulting from carelessness or fraud.

(Continued on Page 2)

Provider Name: _____

_____

_____

Provider Address: _____

_____

_____

_____

_____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____

Authorized Signature: _____ Date: _____

Name printed or typed _____

National Provider Identifier (NPI) to be linked to this Idaho Medicaid number: _____

SECTION II

(To be completed by Providers using a Billing Service)

The Provider agrees to abide by the policies affecting electronic submissions as published in the electronic specification manual for Medicaid claims.

The Provider hereby certifies that _____ is authorized to *(Billing Service)* submit electronic claims on Provider's behalf.

The Provider agrees that if the billing arrangement with the aforementioned billing service is terminated, the Provider will immediately report the termination in writing to the Department or its fiscal agent.

Authorized Signature _____ Date _____

Name printed or typed _____

Mail to: **EDS**
Provider Enrollment
PO Box 23
Boise, ID 83707

Fax to: **EDS**
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757
Ask for *Provider Enrollment*

Hospice Intake Form

Fax to: Idaho Medicaid, Medical Care Management
(208) 332-7280

For recertification please include current H&P (within last 30 days), current care plan (Physician signed within last 30 days), current physician certification, and any status change.

	Initial Election ○	**Re-Certification** ○
Today's Date:		
Agency Information		
Hospice Coordinator		
Agency Contact		
Name of Hospice		
Hospice Medicaid Provider Number		
Address		
Phone Number		
Fax Number		
Patient Information		
Name of Patient	Date of Birth: _____	
Medicaid Number		
Current Address		
Check One of the Following:	○ Skilled Nursing Facility ○ Own Home	○ Intermediate Care Facility for Mentally Retarded ○ Certified Home
Date of Hospice Election		
Date of Death/Revoke		
Diagnosis		
ICD-9 Codes		
Check All of the Following that Apply: Patient has coverage including:	○ Medicare Eligible ○ DD Waiver (Developmentally Disabled) ○ Other In-Home Care, Specify: _____ ○ Healthy Connections: ○No ○Yes ○ Healthy Connections Physicians Referral Number: _____	○ A&D Waiver (Aged and Disabled) ○ PCS (Personal Care Service)
Supporting Documents Required (Please attach the following):	○ Hospice Election Form (Participant Signed) ○ Physician Orders for Hospice (Physician Signed) ○ Healthy Connections Physician Referral Number: _____	○ Current History and Physical ○ Hospice Care Plan (Physician Signed)
Signing Physician	○ Physician is Hospice Agency Employee ○ Physician is Hospice Volunteer ○ Physician is Private Practitioner	

Revised: 12/08

Idaho Department of Health and Welfare

Qualified Providers: Presumptive Eligibility

Provider Agreement

This agreement is between the Idaho Department of Health and Welfare, (hereinafter 'DEPARTMENT') and _____, a provider of service (hereinafter 'PROVIDER').

I. SERVICES

A. PROVIDER shall determine by applying standards contained in instructions supplied by the DEPARTMENT whether or not each applicant meets conditions for presumptive eligibility of pregnant women.

B. PROVIDER shall refer each pregnant Medicaid participant who is unable to obtain prenatal care service from a physician, nurse practitioner, or nurse-midwife to the Departments' care coordinator for their service area.

II. GENERAL PROVISIONS

A. In the performance of the services specified in Section I, the PROVIDER shall utilize only personnel who have attended a DEPARTMENT sponsored training program for presumptive eligibility qualified providers.

B. The PROVIDER shall not disclose any identifying patient/resident information received or obtained by virtue of performance of the Agreement without the express written consent of such individual.

III. I have read and understand this provider agreement and realize that failure to comply with its terms is grounds for immediate termination of this agreement. This agreement supplements the *Medicaid Provider Enrollment Agreement*.

For the Department:	**For the Provider:**
Idaho Department of Health and Welfare	Name:
Medical Care Unit	Street or PO Box:
PO Box 83720	City, State, Zip Code:
Boise, ID 83720-0036	

Supervisor/Designee:

_____

Name of Individual Authorized to Sign for Provider:

_____

Idaho Medicaid Contact Lens Prior Authorization Request

Idaho Medicaid Medical Care
PO Box 83720
Boise, ID 83720-0036
Fax to: **(208) 364-1839**
Phone: **(208) 332-7280**

For departmental use only

PA Number: _____

Reviewed By: _____

Review Date: _____

All information is required.

Provider Name: _____

Provider Number: _____ Phone: _____ Fax: _____

Participant Name: _____ Date of Birth: _____

Medicaid Identification (MID): _____ Date of Service: _____

Contacts requested for review:

Manufacturer: _____ Brand: _____

HCPCS Code (see attachment) : _____ Total number of lenses requested: _____

Type (circle one): PMMA Hydrophilic (Soft) Gas Permeable Scleral

Other (specify): _____

Indicate Current RX Below						
Current Rx		**Spherical**	**Cylindrical**	**Axis**	**Prism**	**Base**
D.V.	O.D					
	O.S.					
N.V.	O.D					
	O.S.					

Medicaid will provide a new supply of contacts once per year. Contacts may be supplied more frequently if there is evidence of a vision change greater than .50 diopters or if medically necessary.

Please include a statement of medical necessity or a dated prescription that shows a .50 diopters vision change if the participant has received contacts within the past year.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

For brands other than those listed on this form, please provide documentation of medical necessity for the specific brand. For more information, visit medunit.dhw.idaho.gov.

Idaho Medicaid Contacts and HCPCS Codes

The following brands of contacts are provided by Idaho Medicaid's vision contractor for participants who need them. All contacts require prior authorization. If there is a medical need for contacts other than the brands listed below, please specify the brand and manufacturer and provide documentation that the patient's needs cannot be met by any of the contacts listed below.

HCPCS	Description	Manufacturer	Brand(s) provided
V2500	PMMA	Lagado	PMMA
V2501	Toric PMMA		
V2502	Bifocal PMMA		
V2503	Color vision deficiency correction, PMMA		
V2510	Gas Permeable	Lagado	SA18 SA32
V2511	Toric Gas Permeable		
V2512	Bifocal Gas Permeable		
V2513	Extended Wear Gas Permeable		
V2520	Soft (Hydrophilic)	Acuvue	Advance Oasys Acuvue 2
		Ciba Vision	Focus Daily O2 Optix
V2521	Toric Soft (Hydrophilic)	Bausch and Lomb	Softlens Toric
V2522	Bifocal Soft (Hydrophilic)	Ciba Vision	Focus Progressive
V2523	Extended Wear Soft (Hydrophilic)	Ciba Vision	Ciba Soft Visitint
V2530	Scleral	Wesley Jessen (Ciba Vision)	Scleral
V2531	Scleral Gas Permeable	Wesley Jessen (Ciba Vision)	Scleral Gas Permeable

From Idaho Department of Health and Welfare Administrative Code *IDAPA 16.03.09.782* regarding vision supplies, and *IDAPA 16.03.09.14* covering medical necessity:

"Contact lenses will be covered only with documentation that an extreme myopic condition requiring a correction equal to or greater than minus four (-4) diopters, cataract surgery, keratoconus, or other extreme conditions as defined by the Department that preclude the use of conventional lenses. Prior authorization is required by the Department."

"A service is medically necessary if: **a.** It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and **b.** There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly."

Idaho Medicaid Dental Medical Necessity Review Form

To Requesting Dental Provider:

Please use this form to request Medicaid review for dental services or oral surgery that is not covered by Medicaid. Requests should only by made for unusual cases when you believe the participant has a medical necessity for the services. ***Please complete this form, attach all required documentation and return all to:***

Division of Medicaid
Dental Unit
PO Box 83720
Boise, ID 83720-0036

Today's Date:	
Participant Name:	
Medicaid Number:	
Date of Birth:	
Dental Provider Name:	Participant's Primary Care Physician:
Address:	Address:
City & Zip Code:	City & Zip Code:
Phone Number:	Phone Number:
Fax Number:	Fax Number:
Provider Number:	

IDAPA: 16.03.09.011.14 Definition of Medical Necessity: A service is medically necessary if: (a) it is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction and (b) there is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly and (c) services shall be of a quality that meets professionally recognized standards of health care and *must be substantiated by records including evidence of such medical necessity and quality. Those records shall be made available to the Department upon request.

*Please attach the following (check each item attached and submit both medical records and dental documentation at the same time):

Supporting participant medical records:

- Participant's present condition
- History of conditions/diseases
- Physician notes including history and physical
- Consultations

Supporting dental documentation:

- Completed Dental Prior Authorization Form (General or Orthodontic)
- X-Rays/diagnostic casts (If applicable)

Idaho Medicaid Dental Program
Dental Prior Authorization Form (General)

Medicaid Participant Information

Last Name: First Name: Initial:

Medicaid ID Number: Date of Birth:

Providing Dentist Information:

Name:

Address:

City: State: Zip Code:

Phone Number: ( ) - Medicaid Provider Number:

Date of Service (If Retro Review)	Tooth	Procedure Code	Description

Remarks:

Place of Service (Check the appropriate box)

○ **Office** ○ **Hospital** ○ **Long-Term Care Facility** ○ **Ambulatory Surgical Center** ○ **Other**

Replacement: ○ **Yes** ○ **No**

Enclosures: ○ **Pano** ○ **X-Ray** ○ **Model(s)**

(Department Use Only) Do Not Write in Boxes Below

Procedure(s) being authorized or denied:

Authorized: Yes No	**Denied: Yes No**	**Reviewer(s) Initials:**	**PA Number:**

IDAPA Reference:

Mail to: Division of Medicaid
Dental Unit
PO Box 83720
Boise, ID 83720-0036

Rev 08/07

Idaho Medicaid Dental Program
Dental Prior Authorization Form (Orthodontics)

Medicaid Participant Information

Last Name: First Name: Initial:

Medicaid ID Number: Date of Birth:

Providing Dentist Information:

Name:

Address:

City: State: Zip Code:

Phone Number: ( ) - Medicaid Provider Number:

Dentition: ○ **Primary** ○ **Transitional** ○ **Adolescent** ○ **Adult**

Please check box to indicate if additional information is attached to the prior authorization form

Treatment Summary Notes ○ **Attached**

Key Factors in Treatment ○ **Attached**

Probable Treatment Plan ○ **Attached**

Procedure Code(s) (Check the appropriate box)

Enclosures: ○ **Pano** ○ **X-Ray** ○ **Model(s)**

(Department Use Only) Do Not Write in Boxes Below

Procedure(s) being authorized or denied:

Authorized: Yes No	**Denied: Yes No**	**Reviewer(s) Initials:**	**PA Number:**

Mail to: Division of Medicaid
Dental Unit
PO Box 83720
Boise, ID 83720-0036

Rev 08/07

Idaho Medicaid Dental Program: EPSDT Request Form (Interceptive Orthodontics)

Medicaid Participant Information:		
Last Name:	First Name:	Initial:
Participant Medicaid Number:	Date of Birth:	
Provider Information:		
Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Provider ID (Medicaid Number):	
Dentition: ○ **Primary** ○ **Transitional**		
Upper Arch Treatment Plan:		
Lower Arch Treatment Plan:		
Length of Treatment:		
Requested Procedure Code (With Arch Designation 01 or 02):		
○ **Enclosures** ○ **Panograph** ○ **Models** (If not previously reviewed)		
(Department Use Only) Do Not Write in Boxes Below		
Procedure(s) being authorized or denied:		
Authorized: Yes No	Denied: Yes No	Reviewer(s) initials: _____ PA Number: _____
IDAPA Reference:		

Mail to: Division of Medicaid
Attn: Dental Unit
PO Box 83720
Boise, ID 83720-0036

Idaho Medicaid DME/Supplies Request Form

State of Idaho **Department of Health & Welfare** **Division of Medicaid** **PO Box 83720** **Boise, ID 83720-0036** **(866) 205-7403**	**Urgent** **Yes** **No**	**Departmental Use Only**

Provider Name: _____

Contact Person: _____ Phone: ( ) _____-_____ Fax: ( ) _____-_____ Provider Number:_____

Provider Address: _____ City: _____ State: _____ Zip:_____

Participant Name:_____ Participant MID: _____ Date of Birth:_____

Participant Address: _____ City: _____ State: _____ Zip:_____

Physician Name/Address:_____

Insurance Information: _____ Diagnosis:_____

Healthy Connections Physician: _____ **Healthy Connections Referral Number: _____**

Description	HCPCS Code	Quantity	Start Date	Stop Date	Price	Rental/ Purchase
Please attach all appropriate medical necessity and pricing documentation to support the request						
Fax: (800) 352-6044						

Idaho Medicaid Electronic PA Request Attachment Cover Sheet

Complete and submit this cover sheet with the required attachment when you submit an electronic HIPAA formatted Prior Authorization Request (HIPAA 278 transaction). We will match the information on this cover sheet with your electronic PA request.

This cover sheet is not required for PA's that are not requested electronically.

Please provide the following information:

Prior Authorization Control Number *Note:* This number must match the control number required on the PA request	
Date electronic PA request was submitted	
Provider 9-digit ID Number	
Participant Name	
Participant's 7-digit Medicaid ID Number	
Date(s) of Service	

Idaho Medicaid Healing Arts Therapy
Prior Authorization Request

To Requesting Provider: Please complete the form, attach required documentation, and fax to (208) 332-7280.

Please fill in all boxes because **all** information is required.

This request is for additional: ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Today's Date:
Participant:
Medicaid ID Number:
Date of Birth:
Phone Number:
Requesting Provider:
Address:
City, Zip:
Phone Number:
Fax Number:
Provider Medicaid ID Number:
Healthy Connections Referral Number:
Prior authorization requested for visits beginning (date): and ending:
Number of visits requested between these dates:
Brief therapy description, ICD-9 and CPT Codes:

The following supporting documents must be attached in order to receive prior authorization:

- ☐ Current Therapy Evaluation
- ☐ Current Plan of Care
- ☐ Current Progress Report
- ☐ Current signed and dated physician order
- ☐ Justification for additional visits demonstrating their medical necessity
- ☐ Copies of therapy note for all treatment within the last 30 days
- ☐ Copies of IEP/IFSP therapy plans, if applicable

Once all documentation is received, we will respond within 24 hours.

Mail or Fax to: Division of Medicaid, Medical Care Unit
Attn: Therapy Reviews
PO Box 83720
Boise, ID 83720-0036

Phone: (208) 364-1904
Fax: (208) 332-7280

Idaho Medicaid Surgery and Medical Treatment Prior Authorization Request

To Requesting Provider: Please complete form, attach required documentation and return

Prior Authorization Request Form

Today's Date:	Proposed Date of Service:	
Participant:	Hospital:	
Medicaid Number:	Inpatient:	Outpatient:
Date of Birth:		
Phone:		
Requesting Provider:	Surgeon:	
Address:	Address:	
City/Zip:	City/Zip:	
Phone:	Phone:	
Fax:	Fax:	
Provider Number:	Provider Number:	

Procedure Description and CPT Codes:

_____
_____
_____
_____

Additional Comments:

_____
_____
_____
_____

Supporting documents required, please attach the following: (Mark all items attached)

- ○ History and Physical
- ○ Consultations
- ○ Provider/Surgeon Notes
- ○ Treatment Plan
- ○ History of Disease
- ○ Present Condition

Mail or Fax to:

Division of Medicaid
Attn: Surgery Reviews
PO Box 83720
Boise, ID 83720-0036

Phone: (208) 364-1854
Fax: (208) 332-7280

Idaho Psychosocial Rehabilitation Services
Service Plan Authorization

(PSR Providers: Please complete all items in this box.)

Provider/Region: _____ Participant Name: _____

Provider #: _____ MID #: _____

Agency Phone: _____ Agency Fax: _____

Medicaid Mental Health PA Unit Use Only

IPA Start Date: _____ PA #: _____

Service Plan Start Date: _____ End Date: _____

Description:	Individual PSR	Group PSR	Collateral Contact *(Modifiers) Telephone HE*	Pharm. Mgmt.	Psychotherapy Ind:	Nursing Services	Other	Other
Code:	H2017	H2014	90887	90862	90804 ☐ 90806 ☐ 90808 ☐ Family: 90847 ☐ Group: 90853 ☐	T1001		
Total approved units per:				Occurrence				

☐ Plan is approved as submitted.

☐ Plan is approved with following modifications:

Units reduced from: _____ to: _____ in: ☐ RHIP-H2017 ☐ RHCC-90887 ☐ RHGP-H2014

Reason for reduced hours: _____

MMHPA Reviewer: _____ Date: _____

Note: Please modify the plan as noted and **keep it in the front of the participant's file**.

Medicaid Non-Emergent Transportation Request

Date/Time:_____ Provider Phone: _____

Region: _____ Provider Name: _____

Provider Fax Number: _____ Provider Number: _____

Participant Information
Participant MID:
Participant Name:
Participant DOB:
Participant Phone:
Participant Address:
Participant City/State/Zip:
Why Not Driving Self:
Medical Services/Reason For Transport:
Participant's Healthy Connections Physician (If applicable):
Special Transport Needs? (Wheelchair Van):
Medical Provider Information
Medical Provider Name:
Medical Provider Phone:
Medical Provider Treatment Address:
Physician Referral Obtained (If service is outside of community):
Transport Information
Dates of Service:
Appointment Time:
Initial Blanket Authorization:
Blanket - Days Of The Week:
Pick-Up Address:
Drop Off Address (End of Transport):
Total Loaded Miles Per Trip:
Services Requested
Procedure Codes Requested:
Units Requested Per Code:
Price Per Unit:
For Medicaid Use Only
Approved / Denied:
DB Completed:
PA Completed:

Outside the Boise Calling Area: (800) 296-0509
Fax Number: (800) 296-0513

Inside the Boise Calling Area: (208) 334-4990
Fax Number: (208) 334-4979

Medicaid Non-Emergent Transport Request Form Instructions

Use these instructions to complete the Transport Request Form. Complete all fields on the form.

Field Name	Description of Required Data
Participant Information	
Participant MID	Complete 7-digit participant Medicaid identification number. It is the responsibility of the requestor to verify current participant eligibility prior to making request.
Participant Name	Name as it appears on the Medicaid ID card.
Participant DOB	Participant's date of birth.
Participant Phone	Phone number where participant/guardian may be reached for verification of request.
Participant Address	Participant's actual physical address (Residence).
Participant City/State/Zip	City, state, zip code for participant's address.
Why Not Driving Self	Explain why the participant needs state-funded transportation. For example, the participant cannot drive due to age, physical disability, there is not a vehicle in the household, or other free resources available such as friends, family members, or charitable organization.
Medical Services/Reason for Transport	Provide only enough information to determine if medical service is a covered benefit. **Example:** "Counseling" is **not** adequate as there are many types of counseling that are not covered such as vocational, marital, etc.
Participant's Healthy Connections Doctor (If applicable)	If participant is enrolled in Healthy Connections, enter name of primary care provider.
Special Transport Needs? (Wheelchair Van)	Enter special needs for this participant such as wheel chair, ambulance, etc.
Medical Provider Information	
Medical Provider Name	Actual name of the clinic or individual medical provider, if a solo practitioner.
Medical Provider Phone	Phone number where appointment can be verified.
Medical Provider Treatment Address	Address where participant will be transported to.
Physician Referral Obtained If request is to transport participant out of their local community to a distant provider, the following documentation is required ⇒	**From The Referring Physician:** • Diagnosis • Reason for the referral to a distant provider • Statement that equivalent services are not available locally • Brief history of the participant's case **From the Distant Receiving Physician:** • Acknowledgement they have accepted this Idaho Medicaid participant • Date and time of appointment • Anticipated medical services to be provided • Estimated length of treatment and follow-up visits based on the referral information received from the referring physician • Statement that the medical services to be provided are not available in the participant's community or at a closer location • Receiving physician understands he/she must contact the Department directly for services requiring prior authorization or extended medical care • Physician's Idaho Medicaid Provider Identification Number (9-digits)

Transport Information	
Dates of Service	From Date: 1st date of transport To Date: Last date of transport. This will be the same date unless request was for a "blanket authorization" to include several dates.
Appointment Time	Time of appointment
Initial Blanket Authorization	Indicate if this is or is not a blanket request.
Blanket – Days of Week	
Pick-Up Address	Physical address where participant will be picked up. May enter "home" if same as participant address.
Drop Off Address (End of Transport)	May enter "home" if being returned home.
Total Loaded Miles Per Trip	
Services Requested	
Procedure Codes Requested	Enter the transportation procedure code you will be billing to Medicaid. Check *Notification of Decision* letter when received to be certain mileage and procedure code are correct PRIOR to billing.
Units Requested Per Code	1 unit = 1 mile. Enter total ROUND TRIP miles for this request. If this is a blanket request, enter TOTAL MILEAGE for the entire blanket authorization that would include all trips.
Price Per Unit	Enter the "price per unit" which should appear on the *Notice of Decision* letter calculated with rate chart.

Medical Necessity Form (pregnancy related)

Participant Name: _____

Participant Medicaid Identification Number: _____

Date of Service: _____

Describe How Service is Pregnancy Related:

_____

_____

_____

_____

_____

Provider signature: _____

Name typed or printed: _____

Idaho Medicaid Provider number: _____

Date: _____

Mail to: EDS
P.O. Box 23
Boise, ID 83707

Information: (800) 685-3757

IDAHO DEPARTMENT OF HEALTH & WELFARE

NDC Detail Attachment

This form is a required attachment for any Idaho Medicaid paper claim billed using a drug HCPCS Code on a CMS-1500 or a UB-04.

PROVIDER NAME: _____ PROVIDER NUMBER: _____ CLIENT NAME:_____

CLIENT ID NUMBER: _____ DATE OF SERVICE: _____

LINE	NDC											DESCRIPTION	UNITS	BASIS OF MEASURE			TOTAL CHARGES
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$
														GM	ML	UN	$

Please fill in:

- The corresponding line number from the CMS-1500 (HFCA-1500) or the UB-04
- The NDC number used
- The drug description
- The actual quantity (units) given to the patient
- Check the appropriate basis of measurement
- The unit price for the NDC

IDAHO DEPARTMENT OF HEALTH & WELFARE

Compound Detail NDC Attachment

This form is a required attachment for any Idaho Medicaid paper claim billed for a compound claim.

PROVIDER NAME: _____ PROVIDER NUMBER: _____ CLIENT NAME:_____

CLIENT ID NUMBER: _____ DATE OF SERVICE: _____

LINE	NDC											DRUG NAME	QUANTITY	UNIT OF MEASURE			INGREDIENT COST	ROUTE OF ADMINISTRATION
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	
														GM	ML	EA	$	

Please fill in:

- Use NDC 00000-0000-00 on your Claim form
- The corresponding line number from the Pharmacy Claim form
- Include every NDC number used
- The drug description
- The quantity for each ingredient
- Circle the appropriate unit of measure
- The total charges for that line item
- The route of administration for the final compound product
- **If any value is left blank, no payment will be made**

IDAHO DEPARTMENT OF HEALTH & WELFARE

Notification of Birth: Anticipated Stays Greater Than 72 Hours

Notification Date _____

Please fill out completely as possible

Section 1 To be completed by the hospital for anticipated stays greater than 72 Hours

Baby's Information	Mother's Information
Full Name:	Name:
Date of Birth:	Date of Birth:
MID Number (From EPICS):	MID Number:
Gender:	AKA:
City of Residence:	County of Residence:

Hospital's Information	
Hospital Name:	Fax Number:
Contact Person:	Contact Number:
E-mail Address:	

Comments: _____

Section 2 To be completed by the Department

Date Baby's MID Number Provided to the Hospital: _____

EPICS Helpdesk: E-mail Epics@dhw.idaho.gov or Fax to: (208) 334-5817

SRS Worker (If known): _____

Response Section:

_____

_____

Instructions

Section 1 To be completed by the hospital for anticipated stays greater than 72 hours.

1.Electronically fill out **Section 1** as completely as possible. (Leave baby's MID Number blank).

2.E-mail the form to EPICS Helpdesk: Epics@dhw.idaho.gov.

3.Use the words '**Notification of Birth'** in the e-mail subject line to provide for easy identification and quick turnaround.

4.Babies hospitalized for 72 hours or less continue to follow your current procedure.

Section 2 To be completed by the Department

1.EPICS Helpdesk researches and processes the request.

2.**Section 2** is completed with the baby's MID Number inserted into **Section 1**.

3.EPICS e-mails the completed form back to the hospital.

Note: Forms received by EPICS Helpdesk during the last four working days of the month will take a little longer to cross into AIM due to EPICS processing cycles.

Order Form Instructions

Use this form to order any of the forms listed from EDS.

- Copy this page as needed.
- Enter your provider name and Idaho Medicaid number
- Enter the quantity needed
- Complete the 'Send to' section. This will be used as the mailing label for your order. Please print.
- Indicate if the materials should be sent to the attention of a person or department.
- After completing the order form, mail it to:
  EDS
  P.O. Box 23
  Boise, ID 83707

Forms can also be ordered by phone. Call MAVIS at (800) 685-3757. Ask for *AGENT.*

Provider Name: _____

Idaho Medicaid Provider Number: _____

Form Name	Form Number	Quantity
Drug Claim Form	352-023	
Notice of Admit or Discharge: NF or ICF/MR	HW0458	
PASARR Screen Form	HW0087	
PCS Assessment and Care Plan	RMU 14.01	
PDN Flow Chart	HW0622	
PDN Addendum	HW0622A	
Physicians Medical Care Evaluation for PCS	HW0603 3/98	
QMRP Assessment	HW0615	
QMRP Visit	HW0621	
Sterilization Consent Form	HW0034	
Sterilization Consent Form (Spanish version)	HW0034—Spanish	
Visit Notes for Supervising Nurses	HW0620	

From: EDS
P.O. Box 23
Boise, ID 83707

Send to: _____
_____
_____
_____

Attention: _____

Personal Care Services Progress Notes

PCS Provider: _____ Medicaid Provider Number: _____
Participant Name: _____ Participant Medicaid Number: _____
Participant Address: _____
Participant Phone Number: _____

I certify that the data on this form is accurate and correct.
Provider Signature: _____ Date: _____
Participant Signature: _____ Date: _____

Date	Bath	Shampoo	Shave	Grooming/Oral Care	Dressing/Undressing	Bladder/Bowel	Nail Care	Ambulate	ROM: Active/Inactive	Turn/Position	Meal Preparation	Feeding	Grocery Shopping	Linen Change	Laundry	Vacuum	Dust	Mop/Sweep	Empty Trash	Clean Bathroom	Clean Kitchen	Empty Catheter Bag	Clean BSD, Leg Bag	Therapy	Transportation	Supervising Nurse	Other	Time In	Time Out	Total Hours

Date	Observations, Changes, Problems

Personal Care Services Progress Notes Instructions

Personal care services providers are required to supply their own forms for Personal Care Services Progress Notes. Providers may make copies of the form on the reverse side of these instructions, create their own version containing the required information pursuant to the Rules Governing Medical Assistance, IDAPA 16.03.10.320.11, or make copies of the older form Alternative Care Services HW 0609 (2/88).

A copy of the participant's progress notes shall be maintained in the participant's home unless authorized to be kept elsewhere by the RMS. Failure to maintain such documentation may result in the recoupments of funds paid for undocumented services.

The following instructions are for the PCS Progress Notes.
Please make copies of this form as needed. It is **not necessary** to include these instructions unless desired by the user.

Instructions:

1. **PCS Provider:** Enter your provider name. This is in the lower right-hand corner of the first page of your remittance advice (RA).

2. **Provider Medicaid Number:** Enter your 9-digit Medicaid provider identification number. Do **not** use a Social Security or FEIN number. This number is in the upper left-hand corner of the first page of your RA.

3. **Participant Name:** Enter the participant's name as it is on the RA. It is found on the Paid Claim page of your RA.

4. **Participant Medicaid Number (MID):** Enter the 7-digit participant Medicaid Identification Number. It is found on the Paid Claim page of your RA following the participant's name. Do not use a Social Security number.

5. **Participant Address:** Enter the address at which the Medicaid participant lives.

6. **Participant Phone Number:** If the participant has a home telephone, enter the number.

7. **Provider Signature/Date:** The person who completes this form must sign and date it.

8. **Participant Signature/Date:** The participant who receives the services must sign and date this form, **unless** it is determined by the RMU that the participant is unable to do so.

9. Indicate the date, type of service(s), time in/out, and total hours for all services provided.

10. Indicate the participant's response to the service, including any changes noted in the participant's condition. Enter any changes in the treatment plan authorized by the referring physician, other provider, supervising registered nurse, or QMRP as the result of changes in the participant's condition.

Request for Additional Crisis Service Coordination Hours

Additional Community Crisis Service Coordination hours are requested in order to facilitate access to emergency community resources, by linking/coordinating, and/or advocating for services. Please complete this form and forward to Office of Mental Health and Substance Abuse.

Participant Name: _____

Number of Hours Requested: _____

Medicaid Number: _____

Service Coordinator:_____ Start Date: _____ End Date: _____

Provider Number: _____

Participant must meet all of the following criteria:

- **Imminent risk (within 14 days) of hospitalization or institutionalization; and**
- **Experiencing symptoms of psychiatric decompensation**
- **Received the maximum number of monthly hours of ongoing and crisis service coordination; and**
- **No other crisis assistance services are available under other Medicaid mental health option services (including) Psychosocial Rehabilitation Services**

Crisis must be precipitated by an unanticipated event, circumstance, or life situation that places the participant at risk of: **(check all that apply)**

○ Hospitalization

○ Losing employment or major source of income

○ Incarceration

○ Physical harm to self or others

○ Becoming homeless (family altercation or psychiatric relapse)

Please document the following information in detail. Attach the service coordination assessment and treatment plan and any applicable progress notes.

1. **Presenting Problem:**

   A. Date crisis began:

   _____

   B. Describe the crisis, include the unanticipated event or circumstance that led to the crisis**.**

   _____

   _____

   _____

   _____

   C. What symptoms of psychiatric decompensation are present?

   _____

   _____

   _____

   _____

Division of Medicaid
Office of Mental Health and Substance Abuse

Shannon Carlin, MS, ACADC
Phone (208) 364-1903 Fax (208) 364-1811
carlins@dhw.idaho.gov

2. Crisis Response History:

Month to Date Totals: Ongoing Service Coordination: _____ Crisis Service Coordination: _____

A. What linking, coordination, or advocacy services have already been provided to resolve this crisis? (Include the number of ongoing service coordination and crisis units or hours already provided during the calendar month.)

_____
_____
_____
_____

B. How does this intervention promote the health and safety of the recipient or prevent hospitalization/ incarceration/out of home placement?

_____
_____
_____
_____

3. Crisis Resolution Plan:

A. Action Plan: What is your agency's response to resolving the crisis? (Be specific and identify what linking, coordinating, or advocacy services will be provided.)

_____
_____
_____
_____

B. How does this intervention promote the health and safety of the recipient or prevent hospitalization/incarceration/ out of home placement?

_____
_____
_____
_____

Participant Name: _____ Agency Name: _____

Signature of Service Coordinator: _____ Phone Number: _____

Date: _____ Fax Number: _____

E-Mail Address: _____

Division of Medicaid
Office of Mental Health and Substance Abuse

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Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person ▶** **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 7[2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.consumer.gov/idtheft* or 1-877-IDTHEFT(438-4338).

Visit the IRS website at *www.irs.gov* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Signature-on-File Form

I hereby certify that I have compared the information submitted regarding materials furnished and services rendered against my records and that the foregoing information is true, accurate, and complete. I further certify that:

- The charges submitted for the material furnished and services rendered are correct charges against the State of Idaho pursuant to applicable Department regulations and State law.
- The claim is due.
- I am authorized to sign for the payee.
- Complete records of materials and services will be provided upon request to the Secretary of the United States Department of Health and Human Services; the Idaho Department of Health and Welfare, and the Medicaid Fraud/SUR Section.
- I accept payment as payment in full, subject to adjustment in accordance with the Department regulations.
- All materials furnished and/or services rendered have been provided without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, physical handicap, or mental handicap.

I understand that payment and satisfaction of all claims submitted with my signature will be from Federal and State funds and that any falsification or concealment of material fact is subject to prosecution under applicable Federal and State laws.

I agree and certify that, for all Medicaid claims submitted with the signature of:

_____,

the terms and conditions of the above statement have been met and will continue to be met.

Authorized Signature: _____

Name Typed or Printed: _____

Idaho Medicaid Provider Number: _____

Date: _____

(The provider or responsible corporate official must sign this certificate statement)

Mail to: EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

Fax to: EDS
Attn: Provider Enrollment
(208) 395-2198

Information: (800) 685-3757

Vision Prior Authorization Request

Idaho Medicaid Medical Care
PO Box 83720
Boise, ID 83720-0036
Phone: **(208) 364-1839**
Fax to: **(208) 332-7280**

For Department Use Only
PA Number: _____
Reviewed By: _____
Review Date: _____

Provider Name: _____

Provider Number: _____ Phone Number: _____ Fax Number: _____

Participant Name: _____

Participant Medicaid Number: _____ Date of Service: _____

Service/Procedure Code Requested for Review:

High Index Lens Procedure Code: _____ Aspheric Lens Procedure Code: _____

Specialty Frame Procedure Code: _____ Early Exam Procedure Code: _____

Lenticular Lens Procedure Code: _____ Other Procedure Code: _____

Please consult your *Provider Handbook* and include all appropriate documentation with requests for procedures or equipment not listed above.

Indicate Current RX Below						
Current Rx		**Spherical**	**Cylindrical**	**Axis**	**Prism**	**Base**
D.V.	O.D					
	O.S.					
N.V.	O.D					
	O.S.					

If RX changed, indicate previous RX below and date of service.

Indicate Previous RX Below						
Current Rx		**Spherical**	**Cylindrical**	**Axis**	**Prism**	**Base**
D.V.	O.D					
	O.S.					
N.V.	O.D					
	O.S.					

Justification, if applicable: Broken ___ Lost ___ Out Grown ___ Vision Change ____

Other: _____

_____

_____

_____

For contacts, use the Idaho Medicaid Contact Lens Prior Authorization Request form.